STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151304	A. BUILDING 00 B. WING	08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSH MEMORIAL HOSPITAL	1300 N MAIN ST RUSHVILLE, IN46173

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A0000	This visit was for a State hospital licensure survey. Dates: 8/22/2011 through 8/24/2011 Facility Number: 005082 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 09/02/11	A0000		
S0554	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation and document review, the facility failed to follow manufacturer's instructions regarding dating of testing supplies to prevent outdated use in 5 of 6 areas using these supplies.	S0554	Tag # S554 410IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.**	08/25/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings included: 1. During the tour of the Radiology Department at 1:45 PM on 08/22/11, accompanied by staff member A10, an open, but not dated, container of OPA Cidex test strips was observed with 20 of the 60 strips remaining in the container. The strips were used to test the Cidex solution for the ultrasound probes. The directions on the container were to not use the strips 90 days after opening. 2. During the tour of the Med/Surg unit at 9:40 AM on 08/23/11, accompanied by staff members A1, A4, and A7, the Contour glucometer and supplies were observed with open, but not dated, bottles of high and low control solutions and a container of test strips. The manufacturer's manual with the meter and supplies stated on page 7, "...4. It is important not to use the test strips or control solution if the expiration date printed on the bottle label and carton has passed or it has been six months (180 days) since you first opened the bottle." 3. During the tour of the Out-patient Surgery area at 10:25 AM on 08/23/11, accompanied by staff member A8, the Contour glucometer and supplies were observed with open, but not dated, bottles		On August 25, 2011 managers of departments that use Cidex and/or glucometers, checked OPA Cidex test stips and Contour glucometer supplies to ensure that “discard after opened” dates were written on the appropriate supplies.If a supply was opened and did not have a date, it was immediately disposed of and a new supply was opened and the discard date was written on the supply container. **2. How are you going to prevent the deficiency from recurring in the future?** Purchasing will compile a list of products that have manufacturer recommendation dates of disposal after opening. This list will include but not be limited to OPA Cidex test strips and Contour glucometer supplies. Purchasing will place an orange sticker on these supplies, alerting staff that use the supplies of the need to review the manufacturer’s recommendations and to list the appropriate discard date.Each department will do random checks at least monthly to ensure that these supplies have discard dates listed on the container. **3. Who is going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc.** Department Directors were responsible for Number 1.Purchasing Department staff and staff that use the supplies are responsible for Number 2.	

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	of high and low control solutions and a container of test strips. 4. During the tour of the Recovery Room at 11:00 AM on 08/23/11, accompanied by staff member A8, the Contour glucometer and supplies were observed with open, but not dated, bottles of high and low control solutions and a container of test strips. 5. During the tour of the Central Processing Department at 11:15 AM on 08/23/11, accompanied by staff member A8, an open, but not dated, container of OPA Cidex test strips was observed on the shelf. The strips were used to test the Cidex solution for the scopes and probes. The directions on the container were to not use the strips 90 days after opening.		**4. By what date are you going to have the deficiency corrected?** August 25th, 2011.	

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A0606	410 IAC 15-1.5-2(f)(3)(D)(viii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and interview, the facility failed to ensure 29 of 30 hospital employees had their Rubella, Rubeola, and Varicella immunizations. Findings included: 1. Rush Memorial Hospital Policy for Rubella and Rubeola states, "All new (individual) (Person) will be required to complete Rubella and Rubeola surveillance at time of pre-employment evaluation. If an employment has documentation of previous Rubella and Rubeola **titer indicating immunity, a copy of that documentation will be acceptable and no f**urther surveillance or testing will be required. If no previous	A0606	Tag # A 606 410 IAC 15-1.5-2 Infection Control 410 IAC 15-1.5-2(f)(3)(D)(viii) **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** The plan has been implemented to ensure all employees have a documented titer for Rubella, Rubeola, and Varicella indicating immunity. All current employee health files have been reviewed to ensure that each employee meets the requirements per policy. Those employees not meeting the requirements will follow the below schedule to be in compliance: The week of September 4, 2011 all employees that report to the VP of Human Resources, VP of Information	10/22/2011

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	titer showing immunity, a Rubella and Rubeola titer will be required and drawn at time of pre-employment health evaluation." 2. At 11:00 AM on 8/24/2011, staff member A18 indicated the facility discovered from previous training that all hospital staff members are required to show proof of immunization of Rubella, Rubeola, and Varicella. However, the hospital does not identify Varicella immunization in the Employee Health Policy. The staff member indicated a policy was prepared but never approved by the board; however, the policy will require the same immunization requirements as Rubella and Rubeola. 3. One of 30 hospital staff health care employee health records did not identify proof of immunization for Rubella (P28). 4. Twenty-three of 30 hospital staff employee health records did not identify proof of immunization for Rubeola (P1, P3, P4, P7, P8, P9, P12, P13, P14, P15, P16, P18, P19, P21, P22, P23, P24, P25, P26, P27, P28, P29 and P30). 5. Twenty-eight of 30 hospital staff employee health records did not identify proof of immunization for Varicella (P1, P2, P3, P4, P5, P7, P8, P9, P10, P11, P12,		Technology, Director of Plant Operations, as well as the Executive Director Foundation, Community & Special Projects Liaison, CEO, and Executive Secretary must get their titer drawn. The weeks of September 11, 2011 and 18, 2011 all employees that report to the VP of Nursing, Quality & Risk must get their titer drawn. The weeks of September 25, 2011 and October 2, 2011 all employees that report to the VP of Finance must get their titer drawn. The weeks of October 9, 2011 and 16, 2011 all employees that report to the VP of Nursing and Physician Practices must get their titer drawn. **Employees that do not show immunity will receive an immunization and then get a second titer three months later. The updated Varicella policy have been revised, reviewed, and approved by the Medical Review Officer (MRO). **2. How are you going to prevent the deficiency from recurring in the future?** A check off form for all new hires will indicate and ensure that they get a titer drawn during the pre-employment screening. **3. Who is going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc.** The Employee Health Coordinator is responsible for numbers 1 and 2. **4. By what**	

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	P13, P14, P15, P16, P17, P18, P19, P20, P21, P22, P23, P24, P25, P26, P27, P28 and P30).		**date are you going to have the deficiency corrected?** October 22, 2011 If the nature of the deficiency precludes completion within the above-stated (30) days, the Plan of Correction must be written in incremental thirty (30) day phases. See attachment “Varicella Policy”	
A0610	410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review, and interview, the facility failed to ensure the cafeteria cold holding unit was	A0610	Tag # A610 410 IAC 15-1.5-2 Infection Control 410 IAC 15-1.5-2(f)(3)(D)(x)No. 136 – During the tour of the kitchen,	09/09/2011

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	maintaining 41 F or less as defined by 410 IAC 7-24, Retail Food Establishment Sanitation Requirements. Findings included: 1. The salad cold plate on the cafeteria serving line was inspected at 12:15 PM on 8/22/2011. The following individual food servings on the cafeteria cold plate holding unit did not maintain 41 degrees Fahrenheit or colder: cottage cheese - 45 F, tuna salad - 43 F, cole slaw - 46 F, and cut watermelon - 53 F. This cafeteria cold holding unit had issues in the past of not maintaining cold items of 41 F or less in 3 previous Indiana State Health Department retail food inspections since 3/14/2005. 2. At 1:00 PM on 8/22/2011, staff member A4 indicated the cafeteria cold holding unit was an issue at least since 2005. The staff member indicated he/she developed a policy of discarding the items that were displayed on the unit within 2 days. The staff member felt the food was not held out of temperature for longer than 4 hours. The food would only be displayed on the cold bar for no longer than 2 hours per day then placed in the refrigerator until the next day. 3. Retail Food Establishment Sanitation Requirements 410 IAC 7-24-187 section		kitchen staff drinks were located above food that was to be served to patients and/or customers. The stand-up cooler had three drinks stored on a shelf directly above a fresh made container of salad designated for a patient. A staff member's drink was stored on a prep table shelf directly above a sheet pan containing "peanut bar". 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All drinks discussed where removed from area immediately. The tally sheet area was designated to keep drinks in use. Any staff drinks or food not in use will be stored in the small refrigerator in the kitchen, designated for employees. 2. How are you going to prevent the deficiency from recurring in the future? The staff member will be responsible for keeping their drinks while in use in the correct area and food/drinks stored in the proper place. Staff was in-serviced on 9/9/11 on the new procedure. 3. Who is going to be responsible for number 1 and 2 above? The supervisor on duty will be responsible for seeing that the staff members follow through with keeping their drinks in the proper area and food/drinks are stored properly. 4. By what date are you going to have the deficiency corrected? The deficiency was corrected on 9/9/11. No. 177 – The cafeteria serving line hand	

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	(2) subsection (ii) states, "..by April 29, 2010, the equipment is upgraded or replaced to maintain food at a temperature of 41 F or less."		sink was located at the end of the prep counter behind the line and there was an assorted food display rack located on the prep counter butted up to the hand sink. There were no barrier between the hand sink and the assorted potato chip display rack to prevent splash of water from hand washing onto individual packages of food. 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The display rack was removed immediately from counter behind the tray line. Until the new snack rack was available, snacks were place on a cart behind the tray line. Snacks are now located in a mobile snack rack that is wheeled out during lunch and placed on the wall beside the cash register. At all other times it is located on the wall behind the tray line next to the kitchen door. 2. How are you going to prevent the deficiency from recurring in the future? Snacks have been moved to a floor mobile cart. Staff was in-serviced on 9/8/11 on the new procedure. 3. Who is going to be responsible for number 1 and 2 above? The cafeteria worker is responsible for filling the rack and making sure it is in the correct location. The Dietary Manager is responsible for seeing the cafeteria worker follows the correct procedure. 4. By what date are you going to have the	

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			deficiency corrected? Started using the new snack cart and following procedure on 9/8/11. No. 187 – The salad cold plate on the cafeteria serving line was inspected at 12:15 PM on 8/22/11. The following individual food servings on the cold plate did not maintain 41°F or colder: cottage cheese - 45°F, tuna salad - 43°F, cole slaw - 46°F, and cut watermelon - 53°F. This cold plate had issues in the past of not maintaining cold items in 3 previous state inspections since 3/14/2005. Therefore, the kitchen cafeteria has violated 410 IAC 7-24-187 section (2) subsection (ii) which states "…by April 29, 2010, the equipment is upgraded or replaced to maintain food at a temperature of 41°F or less." 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. We are in the process of obtaining quotes on updating the equipment for keeping cold food in the cafeteria. We will be replacing the cold plate once those have been received and a decision is made on which is the best option. All potentially hazardous items were discarded on 8/22/11. On 8/23/11 we started placing all potentially hazardous items in ice during serving. Temperatures are taken every 30 minutes and recorded on the cafeteria work sheet. If temperatures is not 41°F or below, the item/items will to be	

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			discarded. The cafeteria work sheet must be signed by the supervisor at the end of each day. 2. How are you going to prevent the deficiency from recurring in the future? The supervisor on duty will be reviewing the cafeteria work sheet to see that temperatures are taken. 3. Who is going to be responsible for number 1 and 2 above? The cafeteria person fills out the work sheet. The supervisor on duty is to review it. 4. By what date are you going to have the deficiency corrected? The policy and procedure was in place on 9/9/11 and staff was in-serviced. No. -191 – Several food items were observed not date marked and the kitchen's policy on date marking for milk and cottage cheese reflected the manufacturer's date labeling not the cumulative refrigerated time after the items were open. The food included: Walk-in cooler – 80-ounce open container of tuna salad, half and half creamer, and a ½ gallon of 2% milk; stand-up cooler – open container of sliced cheeses. 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All items in question were discarded immediately. The Labeling and Dating of Food policy was revised and is attached. Milk and cottage cheese will be given a use-by	

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			date of 7 days from opening. The staff is to initial new label when attached to an item. 2. How are you going to prevent the deficiency from recurring in the future? Staff was in-serviced on 9/9/11 about the new policy. Once a week a designated staff member (different employee each week) will check for items not labeled and dated. They will list items found, who didn't label and date the items and the corrective action taken. 3. Who is going to be responsible for number 1 and 2 above? The staff member who completes the check each week will be designated by the Dietary Manager. She will be responsible for reviewing list to see who isn't labeling make sure the proper corrective actions are taken. 4. By what date are you going to have the deficiency corrected? New policy and procedure was in place by 9/9/11. No. 218 – The walk-in freezer was observed with ice build-up on the condenser drain lines which there was evidence of ice accumulation of the cases of food stored directly under the condensing unit. 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Cases of food on shelf directly below condenser were moved immediately and ice build-up was cleaned up. Nicholas Refrigeration reconnected a thermostat that	

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			triggers a fan which will blow across the coil during defrost to keep it from dripping. We are in the process of obtaining quotes to replace the PVC strip door. 2. How are you going to prevent the deficiency from recurring in the future? The person who receives our order from U.S. Foodservice (usually Monday) will be responsible for seeing that there are not any cases on the shelves below the condenser and checking for ice accumulation. Results will be logged Walk-in Freezer Check along with any corrective action that is taken. 3. Who is going to be responsible for number 1 and 2 above? The person receiving the order from U. S. Foodservice will check the walk-in freezer log the results on the Walk-in Freezer Check each week . Results will be reported to the Dietary Manager and she will initial the results. 4. By what date are you going to have the deficiency corrected? Staff was in-serviced on 9/9/11 on the new procedure and it was implemented at that time. See attachments:2011091419310570 5Cafeteria WorksheetItems not LabeledPersonal ConductSalad Bar Cold CartWalk-In Freezer	

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S0754	410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. Based on document review, medical record review, and interview, the facility failed to ensure the Consent for Service forms were completed according to policy for 8 of 25 patient records reviewed (#N3, N5, N6, N11, N13, N14, N19, and N24). Findings included: 1. The facility policy titled "Medical Records Entry Policy" stated under 6. Timeliness, "...c. Identifiable and clearly noted date and time (month, day, year, time using military time.)" 2. The facility policy titled "General Consent for Treatment" stated, "...Consent for treatment should be obtained in writing from the adult patient. If the patient is a minor, then written consent should be obtained from his/her parent or legal guardian. The policy continued under the explanation of the order of responsibility for other signatures, "... (NOTE: the relationship of the person giving consent to the patient should be indicated following the person's signature.)" The policy also stated, "...Hospital staff may witness patient signatures and sign as witnesses on patient consent forms."	S0754	Tag # S754 410 IAC 15-1.5-4 Medical Record 410 IAC 15-1.5-4(f)(5) **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** Staff has been educated on how to properly complete consents. This education took place at staff meetings on August 31 and September 1, 2011. **2. How are you going to prevent the deficiency from recurring in the future?** The data specialist began reviewing all consents starting with September 1, 2011 admissions. Each time a consent is completed improperly, the staff member responsible for completing the consent will be alerted. Trends and patterns will be followed and individual staff members will be remediated accordingly.The Data Specialist has started a Quality Assurance	09/01/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSH MEMORIAL HOSPITAL	1300 N MAIN ST RUSHVILLE, IN46173

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. The general consent for treatment and services for patient #N3 lacked a date and witness signature. 4. The general consent for treatment and services for patient #N5 lacked a date and witness signature. 5. The general consent for treatment and services for patient #N6, a minor, lacked a date, relationship of person signing, and witness signature on the top portion and a relationship of person signing on the bottom portion. 6. The general consent for treatment and services for patient #N11 lacked a date and witness signature. 7. The general consent for treatment and services for patient #N13 lacked a date and witness signature. 8. The general consent for treatment and services for patient #N14 lacked a date. 9. The general consent for treatment and services for patient #N19 lacked a witness signature. 10. The general consent for treatment and services for patient #N24 lacked a date and witness signature. 11. At 12:30 PM on 08/24/11, staff members A7 and A14 confirmed the medical record findings.		monitor that will be reported quarterly to the Quality Assurance Committee regarding incomplete consents. **3. Who is going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc**. The Medical Surgical Director completed Number 1.The Data Specialist is responsible for Number 2. **4. By what date are you going to have the deficiency corrected?** September 1, 2011.	

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S0781	410 IAC 15-1.5-4(i)(2) (i) Emergency service records shall document and contain, but not be limited to, the following: (2) Time of arrival, means of arrival, time treatment is initiated, and time examined by physician, if applicable. Based on medical record review and interview, the facility failed to ensure 3 of 5 (#N6, N18, and N21) emergency room records had the required documentation regarding admission on the forms. Findings included: 1. The Emergency Physician Record for patient #N6 lacked documentation of date, time, means of arrival, and time examined by the physician. 2. The Emergency Physician Record from 01/04/11 for patient #N18 lacked documentation of time of arrival and time examined by the physician. 3. The Emergency Physician Record from 12/23/10 for patient #N21 lacked documentation of time of arrival, means of arrival, and time examined by the physician. 4. At 12:30 PM on 08/24/11, staff members A7 and A15 confirmed the medical record findings.	S0781	Tag # S781 410 AIC 15-1.5-4 Medical Record Services 410 AIC 15-1.5-4(i)(2) **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** A designated Emergency Department staff member will review charts daily including physician charting starting September 16, 2011. If a chart has incomplete documentation including but not limited to arrival, means of arrival, date, time, and examination time, the staff member will route the chart to the appropriate person for completion of the chart. **2. How are you going to prevent the deficiency from recurring in the future?** The Emergency Department staff designated to review the charts will track which physicians and staff members who do not complete the chart. The Medical Director of the Emergency Department and the Director of the Emergency Department will remediate staff individually who do not complete the chart correctly. **3. Who is**	09/16/2011

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			going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc. A designated staff member will be responsible for Number 1.The Medical Director of the Emergency Department and the Director of the Emergency Department will be responsible for Number 2. **4. By what date are you going to have the deficiency corrected?** September 16, 2011	
S0787	410 IAC 15-1.5-4(i)(8) (i) Emergency service records shall document and contain, but not be limited to, the following: (8) Diagnostic impression and condition on discharge documented by the practitioner, and disposition of the patient and time of dismissal. Based on medical record review and interview, the facility failed to ensure 5 of 5 (#N6, N7, N8, N18, and N21) emergency room records had the required documentation regarding condition on discharge and time of dismissal on the forms. Findings included: 1. The Emergency Physician Record for patient #N6 lacked documentation of a date or condition on discharge. 2. The Emergency Physician Record for patient #N7 lacked documentation of a condition on discharge. 3. The Emergency Physician Record for patient #N8 lacked documentation of a condition on	S0787	Tag # S787 410 AIC 15-1.5-4 Medical Record Services 410 AIC 15-1.5-4(i)(B) **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** A designated Emergency Department staff member will review charts daily including physician charting starting September 16, 2011. If a chart has incomplete documentation including but not limited to documentation of date of discharge, time of discharge, or condition on discharge, the staff member will route the chart	09/16/2011

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	discharge. 4. The Emergency Physician Record for patient #N18 lacked documentation of a time or condition on discharge. 5. The Emergency Physician Record for patient #N21 lacked documentation of a condition on discharge or the disposition of the patient. 6. At 12:30 PM on 08/24/11, staff members A7 and A15 confirmed the medical record findings.		to the appropriate person for completion of the chart. **2. How are you going to prevent the deficiency from recurring in the future?** The Emergency Department staff designated to review the charts will track which physicians and staff members do not complete the chart. The Medical Director of the Emergency Department and the Director of the Emergency Department will remediate staff individually who do not complete the chart correctly. **3. Who is going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc.** A designated staff member will be responsible for Number 1.The Medical Director of the Emergency Department and the Director of the Emergency Department will be responsible for Number 2. **4. By what date are you going to have the deficiency corrected?** September 16, 2011	
S0952	410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, medical record review,	S0952	Tag #S 952 410 IAC 15-1.5-6	09/01/2011

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	and interview, the facility failed to ensure staff followed their policy for blood administration in 5 of 5 records reviewed of patients who had received blood transfusions (#N1, N2, N3, N4, and N5). Findings included: 1. The facility policy titled "Blood and Blood Product Administration", last revised 01/2010, stated, "...Positive patient and blood identification must be performed and documented prior to each transfusion. ...Verify patient's name, medical record number, date of birth, band number, donor unit number, unit outdate, ABO/RH of patient, ABO/RH of donor unit, physician's order and correct product at bedside with a nurse (Registered Nurse or Licensed Practical Nurse)." The policy continued under procedure, "...Continue to check and record vital signs according to the Blood Product Transfusion Form and monitor patient for signs and symptoms of transfusion reaction." 2. The Blood Product Transfusion Form for a unit of blood started at 0150 on 05/25/11 for patient #N1 lacked a check in the box for the consent signed by the patient. The time for the vital signs due at 30 minutes, the 3rd hour, and 1 hour post transfusion were written over/changed. The medical record did evidence a signed consent form for the blood transfusion. 3. The Blood Product Transfusion Form for a unit of blood started at 0135 on 07/19/11 for patient #N2 lacked a check in the box for the medical record number check. 4. The Blood Product Transfusion Form for a unit of blood started at 1535 on 07/06/11 for patient #N3		Nursing Service 410 IAC 15-1.5-6(d) **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** Medical-Surgical staff members were educated on the correct procedure for completing blood transfusion forms on August 31, 2011 and September 1, 2011. **2. How are you going to prevent the deficiency from recurring in the future?** Director of Lab will monitor all blood transfusion forms. If a form is not completed correctly, she will immediately notify the Medical-Surgical Director and the Vice-President of Quality and Risk. Each staff member not completing the form correctly will be remediated on correct procedure for completing blood transfusion forms. **3. Who is going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc**. Medical –Surgical Director is responsible for Number 1; education of completing forms.The Director of Lab is responsible for Number 2; notifying the Medical-Surgical Director and VP of Quality and Risk of forms not completed correctly. 4. By what date are you going to have the deficiency	

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	lacked a check in the box for the band number check. A second unit was started at 2025 on 07/06/11 and the form lacked a check in the box for the consent signed by the patient and the time for the pre-transfusion and the 3rd hour vital signs was written over/changed. The medical record did evidence a signed consent form for the blood transfusion. 5. The Blood Product Transfusion Form for a unit of blood started at 1720 on 07/03/11 for patient #N4 evidenced the unit was completed and discontinued at 2025, but the 1 hour post transfusion vital signs were documented as 2250. 6. The Blood Product Transfusion Form for a unit of blood started at 1725 on 06/29/11 for patient #N5 evidenced the unit was completed and discontinued at 2050, but the 1 hour post transfusion vital signs were documented as 2255. The form for a second unit of blood started at 2255 on 06/29/11 lacked a check in the box for the consent signed by the patient. The medical record did evidence a signed consent form for the blood transfusion. 7. During the review of the medical records at 3:15 PM on 08/23/11, staff member A7 confirmed the findings on the Blood Transfusion Forms.		corrected?September 1, 2011	

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S1014	410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals. Based on document and policy review, observation, and interview, the facility failed to follow its policies regarding storage, usage, and monitoring of medications in the surgical area and pediatric building. Findings included: 1. The facility Pharmaceutical Services policy #PH-41 regarding Multi-Dose Vials stated, "Multi-dose vials are to be treated as single-use vials. Single use vials will be used one time and discarded according to proper manufacturer guidelines." The policy continued to list insulin, skin tests, and vaccines as exceptions to this single dose classification. 2. The facility Pharmaceutical Services policy #PH-25 regarding Approved Floor Stocks, Recordkeeping, and Accountability stated, "...1. The pharmacist or his designee will make monthly inspections of all floor stock areas. 2. Inspections will be documented. 3. A listing of all floor stock quantities will be maintained in the pharmacy." 3. The facility Pharmaceutical Services policy #PH-10 regarding Drug Samples by Pharmaceutical Representatives stated, "1. Drug samples will not be distributed in the hospital. 2. The ER Department will not distribute samples. 3. Office samples will be logged in and out and be	S1014	Tag # S1014 410 IAC 15-1.5-7 Pharmaceutical 410 IAC 15-1.5-7(c) **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** Surgery – multi dose vials:Pharmacy will do daily checks in the surgery department. Any open vials will be disposed of properly and restocked.Surgery staff members will also do daily checks.These daily checks were started on August 24, 2011. Physician Office Sample Medications:Physician Office staff will complete monthly checks for count correctness and expiration dates.Pharmacy staff will complete monthly checks for count correctness and expiration dates.The Director of Pharmacy will do random checks to ensure that the checks are being completed and are being completed correctly. These checks began September 1, 2011. On September 19, 2011, the Director of Pharmacy instructed physicians on designated secured areas of	09/19/2011

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	checked monthly for expiration." 4. At 2:15 PM on 08/23/11, the pediatric building was toured with staff members A1, A4, and the director, A11. The Pharmacy Room Medication Log was reviewed and the following documentation was evidenced: A. The log sheet for Topicort Ointment 0.25 % indicated a count of 20 on 02/09/11. The form had documentation of 10 samples given to the physician for his office on 07/13/11, leaving 10 remaining. Documentation of a "Count Correction" from 07/15/11 indicated the number left was now 0. B. The log sheet for Topicort Cream 0.25 % indicated a count of 20 on 02/09/11. The form had documentation of 10 samples given to the physician for his office on 07/13/11, leaving 10 remaining. Documentation of a "Count Correction" from 07/15/11 indicated the number left was now 6. C. The log sheet for Asmanex Twisthaler 110 micrograms (mcg) indicated a count of 3 remaining on 10/04/10. Documentation of a "Count Correction" from 07/15/11 indicated the number left was now 1. D. The log sheet for Tamiflu indicated a count of 33 remaining on 01/25/11. Documentation of a "Count Correction" from 07/15/11 indicated the number left was now 31. E. The log sheet for Children's Tylenol indicated a count of 5 remaining on 03/15/11. Documentation of a "Count Correction" from 07/15/11 indicated the number left was now 1. F. All of the sheets lacked documentation of any explanation for the count correction to change the number remaining. 5. The pharmacy department monthly check sheet for the pediatric building indicated "Our Drugs"		storage for medications. **2. How are you going to prevent the deficiency from recurring in the future?** Pharmacy will do daily checks to ensure that there are no open vials. Surgery staff members will do daily checks to ensure that there are no open vials.Physician Office staff will do monthly checks to ensure count correctness and no expired medications.Pharmacy staff will do monthly checks to ensure count correctness and no expired medications. A Reconciliation Policy was developed in order to consistently correct medication counts. A Sample Policy has been implemented to assure that medications can be reconciled when counts are not correct. Nursing staff was informed to store all medication in designated areas. Medications are not to be stored in offices, counters, work stations, or non-secure areas. **3. Who is going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc.** A designated surgery staff (nurse) will be responsible for checking for opened vials daily.Pharmacy staff will do daily checks. The Pharmacy Director will do random checks to ensure that the daily checks are completed. The Pharmacy Director will also add the daily checks as a Quality Assurance monitor that will be reported to the Quality Assurance Committee quarterly. **4. By what**	

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	were last checked for expired drugs, opened vials, and correct amounts on 07/01/11, but no date was documented under "Sample". 6. During the tour of the surgical department at 10:40 AM on 08/22/11 and accompanied by staff member A8, the anesthesia cart #1 in OR #2 was opened and the following items were observed in the drawers: A. An open 10 milliliter (ml) vial of Neostigmine, dated 08/19. B. An open 20 milligrams (2 mg./ml.) vial of Etomidate with a needle and syringe piercing the rubber stopper. C. An open 5 mg./2 ml. vial of Droperidol with a needle and syringe piercing the rubber stopper. D. An open 4 mg./ml. vial of Naloxone HCL with a needle and syringe piercing the rubber stopper. 7. At 10:45 AM on 08/22/11, staff member A8 indicated multi-dose vials were not used in the surgical areas. 8. At 2:20 PM on 08/23/11, the director of the pediatric building, staff member A11, indicated the nurses did monthly checks of all of the samples and medications, but there was no documentation of these checks. 9. At 2:30 PM on 08/23/11, staff member A14 indicated he/she could not explain what happened to the medications when the counts were corrected, but that was how he/she was instructed to record the counts when he/she started at the pediatric building. 10. At 2:45 PM on 08/23/11, the facility pharmacist, staff member A12, indicated the pharmacy department did spot checks of the medications monthly. He/she indicated the		**date are you going to have the deficiency corrected?** September 19, 2011 See attachments: Reconciliation Policy, Sample Policy, and Medication Storage Policy, Pharmacy Room Inspection Log	

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	physician's offices were not monitored. He/she also indicated the facility did not use multi-dose vials except for insulin, skin tests, and vaccines.			
A1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and interview, the facility failed to ensure the maintenance shop bench grinding wheel had safety guards and the outside generator with exposed batteries containing acid; the housekeeping closet that mixes bulk chemicals have an eye washing station that meets 15 to 20 minutes of continuous eye flushing. Findings included: 1. At 1:15 PM on 8/22/2011, the maintenance shop was inspected. A work table was observed with a mounted bench wheel for grinding and finishing. The bench grinder did not have any safety guards to protect a persons eyes from sparks and metal shavings.	A1118	Tag # A1118 410 IAC 15-1-5-8 Physical Plant 410 IAC 15-1-5-8(b)(2) **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** The shop bench grinding wheel was removed the day of the survey, August 22, 2011. It will no longer be used. The batteries containing acid were replaced with non-acid batteries on September 9, 2011. The Maintenance Department installed an eye wash station in the housekeeping closet that mixes bulk chemicals. The Director of Environmental Services will train staff members on proper use of the eye wash station. The Director of	09/16/2011

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	2. At 1:20 PM on 8/22/2011, the Physical Plant Director indicated the shop does not have any safety guards for the bench grinder and the bench grinder should have them. 3. American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and/or Shower Equipment, states at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard. 4. At 2:10 PM on 8/22/2011, the outside generator within an out building was inspected. The generator had 2 large car batteries that contain acid sitting next to the generator. The shed did not have any eye washing kit that would meet the needs if a staff member would get acid splashed into their eyes, The Physical Plant Director confirmed the two large batteries were not acid free batteries.		Environmental Services will assign staff to check functionality of eyewash station monthly. These checks will be reported quarterly in Quality Improvement Committee. **2. How are you going to prevent the deficiency from recurring in the future?** The grinder was removed, the acid-containing batteries were replaced, and an eye wash station has been added to the housekeeping closet. **3. Who is going to be responsible for numbers 1 and 2 above: i.e. director, supervisor, etc.** The Director of Physical Plant removed the bench grinder and replaced the batteries containing acid with non-acid batteries.The Maintenance Department installed an eye wash station in the housekeeping closet in which chemicals are mixed.The Director of Environmental Services will be responsible for assigning staff to check the eye wash station monthly to ensure functionality. The Director of Environmental Services educated the housekeeping staff on proper use of the eye was station. **4. By what date are you going to have the deficiency corrected?** The bench grinder was removed August 22, 2011.The batteries were replaced September 9, 2011 with non-acid batteries.The eye wash station	

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			was installed and working on September 16, 2011.Education for proper use of the eye wash station began on September 16, 2011.	